C4S Plan of Care

(For Behavioral Health and Medical Services)

When an evaluation indicates that services are required, a Plan of Care must be developed.*To be completed within 30 days of First Initial Contact for Ongoing Services (Medicaid Requirement)*

Student Name:		DOB:
District:	Building:	Grade:
School Year:	Teacher:	

Participants:

Parent/Guardian:	Parent/Guardian:
Mental Health Provider:	Mental Health Provider:
Administrator:	Other:
Written Consent given on _____by_____ ***Verbal Consent* given on _____by_____*** **Verbal consent can be provided in the event of crisis but local district must still obtain written consent.*	

Student Profile:

Student and Family Strengths:
Description of Medical or Behavioral Conditional or Diagnosis:
High-risk behaviors being displayed?
District and Parent Comments/Concerns:

Progress Monitoring/Plan for Reaching Goals:

Long Term Goal (which serve as an indicator when services are no longer needed):	
Frequency:	Duration:
Short-Term Measureable Objective:	
Frequency:	Duration:
Short-Term Measureable Objective:	
Frequency:	Duration:

Service Plan:

Start Date:	End Date:
Primary Care Provider (PCP):	
How will progress be monitored?	
Statement detailing coordination of services with applicable providers:	
Anticipated Needs and Other Comments:	

Signature Page:

Parent/Guardian ***Date***

Youth Intervention Specialist ***Date***
